

## **PHARMACY & THERAPEUTICS COMMITTEE**

**Meeting 05/28/2008**

Present: Tom Simpatico, Kate Plummer, Brenda Wetmore, Steve Barden, Tommie Murray, Sarah Merrill

Absent: Mary Beth Bizzari, Deb Bard

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### **Topic 1: ROSIE/QUANTROS Medication Event Reports**

Discussion: Committee reviewed reports generated from the new event reporting system ROSIE/QUANTROS. Kudos were given to the nursing staff on B2 as they had the highest percentage of reporting in the new system.

Medication errors- For medication errors, the most frequent event nature/subnature to be reported through 05/28/2008 was “Other issue not on list” and the second most frequent was “Drug omitted”. The committee discussed the potential causes of “drug omitted” as human error due to a chaotic medication-giving environment and potential transcription errors, especially when patients transfer between units as the new attendings are required to re-write all patient orders.

Narcotic variances- The reports regarding narcotic variances raised the committee’s discussion of monitoring for potential narcotic diversion problems at VSH.

ADRs- The reports regarding ADRs indicated that there were three Category F ADRs through 05/28/2008. The investigations into the ADRs have been completed. It was noted that there has been an increase in the reporting of ADRs since the mandatory nursing in-service on ADRs presented by the VSH Education and Training Department at the beginning of May 2008.

Action Plan: The Quality Department will drill down further into the medication event reports to determine the characteristics of the most frequently reported events. For the next P & T committee meeting, Quality will present more detailed analysis of the ROSIE/QUANTROS reports. Quality will also examine narcotic variance reports more closely, specifically the investigation and follow-up of reported narcotic variances. This information will be shared with the P & T committee and VSH leadership. Nursing leadership will provide feedback to nursing staff re: the reporting of ADRs to continue to promote and encourage reporting of all potential ADRs. Dr. Simpatico will complete his write-up of the investigations of the three Category F ADRs using the ROSIE/QUANTROS follow-up investigation template.

### **Topic 2: Night closet**

Discussion: The committee discussed the current nursing practice of accessing medications from the night closet when the VSH pharmacy is closed. Currently, if the pharmacy is closed and a medication is not available in the night closet, the nursing

supervisor may enter the pharmacy to retrieve the prescribed medication. The committee discussed how nursing should not be entering the pharmacy and that there needs to be clear guidelines for off-shift and weekend staff re: access to medications when the VSH pharmacy is closed. The committee discussed potential options to include a PIXIS machine (very expensive and not a full pharmacy either), virtual pharmacy services (VSH pharmacist was unable to locate a company that had coverage available in Vermont), use of FAHC's pharmacy (unclear if VSH has a memorandum of understanding with FAHC for pharmacy services) and use of Vincent's pharmacy (closes at 7pm). The committee discussed simplifying the process to only using Vincent's when the VSH pharmacy is closed. The committee also discussed problems with the night closet to include lack of stock of emergency medication and the limited supply of medications in the night closet due its small size.

Action plan: Quality to meet with pharmacist and pharmacy technician to review use of medication that is not available in the night closet. The pharmacy log of nursing staff entering the pharmacy and for which medication will be reviewed. The nursing administrator will be consulted for clarification of the use of night closet and nursing entering the pharmacy. The need to have a near-term solution discouraging and ending the practice of nursing supervisors entering the pharmacy for medications was stressed.

### **Topic 3: Medication Re-order forms**

Discussion: The committee raised issues that the units, the physicians and the pharmacist are having with the medication re-order forms to include conflicting orders due to medication orders changing frequently, the confusion between the physician order form and the medication re-order form, the struggle for the medication RNs to maintain accuracy, and the need to remind the physicians to complete the forms. The committee was informed that medications have to be reviewed at least monthly. The potential option of incorporating the medication review into the physician's weekly comprehensive progress notes was discussed. The medication re-order form could be altered from an order to just a part of the clinical record.

Action plan: VSH physicians will be consulted re: the idea of incorporating the premise of the medication re-order form into their weekly comprehensive progress notes. The medication re-order form would now be titled the medication review form and be a part of the clinical record.

### **Topic 4: Protocol forms**

Discussion: The medication protocol forms were noted to be very time-consuming. Committee members raised the issue that the physicians may forget to complete them. B1 reportedly is trying to bundle the protocol-required labs if a patient is on more than one protocol.

Action plan: This topic was deferred to the next P & T Committee meeting.

Next meeting: To be scheduled for the end of June 2008.